



# SOUTH DAKOTA BOARD OF NURSING

## SOUTH DAKOTA DEPARTMENT OF HEALTH

### LICENSURE BY ENDORSEMENT

South Dakota joined the Multistate [Nurse Licensure Compact](#) January 1, 2001. If your primary state of residence (where you hold a driver's license, pay taxes, and/or vote) is also a Compact State, you are not eligible for licensure in South Dakota. To check the status of your state, see [www.ncsbn.org](http://www.ncsbn.org).

#### GENERAL ENDORSEMENT APPLICATION INSTRUCTIONS

Please read this information carefully; any omitted steps may cause delays in processing of your application. You can expect that it will take three to four weeks before all forms are received by the Board office so that your application can be considered for approval. Applications for licensure by endorsement are maintained for one year; if the process has not been completed in one year, the application will be destroyed and fees forfeited.

#### 1. APPLICATION AND FEES

- Complete General Application [Form 1](#).
- Fee payment of \$100 in the form of a money order or a cashier's check should be made payable to the South Dakota Board of Nursing. See [Step 5](#) if a temporary permit is also desired.

#### 2. VERIFICATION OF LICENSE

Complete Part I of [Form 2](#) and send it to the [Board of Nursing in the state](#) where you were originally licensed as a nurse. To expedite the process, contact that Board of Nursing to determine whether you should enclose a fee with Form 2. That Board will return the completed form directly to the South Dakota Board of Nursing. If your original state of licensure requires verification of licensure through NURSYS, please use the form available at the [NURSYS](#) website or enclosed form. To check whether your state verifies through NURSYS, see <https://www.nursys.com/> for a list of participating states.

#### 3. VERIFICATION OF EMPLOYMENT

- To obtain or retain an active status nursing license, you must provide verification of employment in nursing of at least 140 hours in any 12-month period, or an accumulated 480 hours within the preceding 6 years. Individuals who engage in nursing practice on a volunteer basis may apply those hours as employment verification. If you are unable to verify employment, contact the Board office for information concerning a Nurse Refresher Course.
- Fill in the top portion of [Form 3](#) and send it to your employer/former employer for completion; the completed form will be sent to the South Dakota Board of Nursing.

#### 4. REQUEST FOR TRANSCRIPT

Complete [Form 4](#) and send it to the Office of the Registrar of the basic nursing education program which prepared you for initial licensure. An official transcript, not a student copy, is required. Contact your Registrar's office to determine whether you should enclose any fee with Form 4.

#### 5. TEMPORARY PERMIT APPLICATION

- A temporary permit is required to practice nursing while awaiting licensure by endorsement. A temporary permit or license is required before you begin orientation at your place of employment.
- Temporary permits are issued for one 90-day period and are not renewable.
- A temporary permit may be issued upon receipt of all of the following:
  1. Form 1 (General Application) and \$100 fee;
  2. Temporary Permit Application and \$25 fee;
  3. Form 3 (Verification of Employment); and
  4. Photocopy of a current RN/LPN license bearing an expiration date.

#### 6. CRIMINAL BACKGROUND CHECK

1. Pursuant to South Dakota law, each applicant for initial licensure is required to submit a full set of fingerprints with completed application to obtain a state and federal criminal background check.
2. Contact South Dakota Board of Nursing to request that a criminal background check packet be sent to you.
3. The fingerprint cards you receive from SDBON **must** be the cards you use for fingerprints, since specific agency data are pre-printed on them.
4. Contact your local law enforcement agency for fingerprinting.
5. Send to the SD Board of Nursing office your completed fingerprint cards and a separate check or money order for \$39.25 payable to: South Dakota Division of Criminal Investigation (DCI).
6. Your application will not be processed and/or temporary license will **not** be issued until your completed application **and** fingerprint cards are received.
7. You will **not** receive a permanent license until the fingerprint results from DCI and the Federal Bureau of Investigation (FBI) are received by the Board, approximately 1-2 weeks.
8. Cards will be rejected if bent, folded, tampered with, stained, smeared, or stapled. If rejected, you will be notified to resubmit your cards.



# SOUTH DAKOTA BOARD OF NURSING

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Form 1: page 1 of 2

### APPLICATION FOR LICENSURE BY ENDORSEMENT

**All information on Form 1 below to be completed by Applicant.**  
**Please type or print in black ink. Note: Fees are non-refundable.**

I. DEMOGRAPHIC DATA									
<b>Current licensure:</b> <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> CRNA <input type="checkbox"/> CNP <input type="checkbox"/> CNM <input type="checkbox"/> CNS									
<b>Name:</b> _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>First</span> <span>Middle</span> <span>Maiden</span> <span>Last</span> <span>Other(s):</span> </div>									
<b>Address</b> _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Street or PO Box</span> <span>City</span> <span>State</span> <span>ZIP</span> </div>									
Home Telephone: _____			Other Telephone: _____			Email: _____			
Date of Birth: _____ ____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female		US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No		SS#    _____			
Race or Ethnicity:		Caucasian	Black	Hispanic	Asian or Pacific Islander	American Indian or Alaskan Native		Other:	
II. PRELIMINARY EDUCATION									
	Institution Name & Location			Dates Attended		Year of Graduation		Degree Granted	
High School or Equivalent								<input type="checkbox"/> Diploma <input type="checkbox"/> GED	
College or University (Non-Nursing)									
III. PROFESSIONAL EDUCATION									
	Institution Name & Location			Dates Attended		Year of Graduation		Degree Granted	
Basic Program in Nursing									
Additional Nursing Education									
Additional Nursing Education									
IV. LICENSURE HISTORY									
State		Licensure		License #		Year Issued		Expiration Date	
Original State:		<input type="checkbox"/> RN	<input type="checkbox"/> LPN						
Other State:		<input type="checkbox"/> RN	<input type="checkbox"/> LPN						
Other State:		<input type="checkbox"/> RN	<input type="checkbox"/> LPN						
Other State:		<input type="checkbox"/> RN	<input type="checkbox"/> LPN						
Other State:		<input type="checkbox"/> RN	<input type="checkbox"/> LPN						
Other State:		<input type="checkbox"/> RN	<input type="checkbox"/> LPN						

V. DISCIPLINARY		
1. Have you ever been convicted, pled guilty or not contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? <b>If Yes, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communications with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.</b>	Yes	No
2. Is there any pending criminal prosecution against you which would constitute a felony?	Yes	No
3. Are you currently being investigated or is disciplinary action pending against any professional licenses(s) or certificate(s) held by you?	Yes	No
4. Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	Yes	No
5. Have you ever had privileges revoked, reduced, or otherwise restricted in any hospital or other healthcare entity?	Yes	No
6. Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	Yes	No
7. Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	Yes	No
8. Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	Yes	No
9. Do you currently owe child support arrearages in the amount of \$1,000 or more?	Yes	No
<b>For 2-9 above, provide an explanation for each Yes response on a separate piece of paper, with a complete description of dates and events. You must also send ALL supporting applicable documents.</b>		
VI. EMPLOYMENT		
List your last six years of nursing employment. If you have not worked in nursing, please explain.		
Dates of Employment	Institution	City/State
From: To:		
From: To:		
From: To:		
From: To:		
From: To:		
VII. DECLARATION OF PRIMARY STATE OF RESIDENCE		
<input type="checkbox"/> I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: _____. This state is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes." Note: If a resident of another compact state, must place license on inactive in other party state. - OR - <input type="checkbox"/> I am employed by the federal government, and so am not affected by Nurse License Compact requirements regarding Primary State of Residence. Name of Employer: _____.  Signature of Applicant: _____ Date: _____		
VIII. AFFIDAVIT		
I declare and affirm, under the penalties of perjury, that this application for licensure as a nurse in South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.		
Signature of Applicant: _____ Date: _____		



# SOUTH DAKOTA BOARD OF NURSING

## SOUTH DAKOTA DEPARTMENT OF HEALTH

Form 2: page 1 of 2

### VERIFICATION OF LICENSE

**Complete Part I, then forward Part I to the Board of Nursing in the state where you were originally licensed. Most states charge a fee for verification of licensure; to save processing time, contact that state Board to determine the appropriate fee to enclose with this form.**

PART I: TO BE COMPLETED BY APPLICANT AND FORWARDED TO ORIGINAL STATE OF LICENSURE					
<b>Name:</b> _____					
First	Middle	Maiden	Last	Other(s):	
<b>Address</b> _____					
Street or PO Box		City	State	ZIP	
Home Telephone: _____		Other Telephone: _____		Email: _____	
Date of Birth: _____			SS# _____		
Nursing Education Program:	Institution: _____		Degree Granted: _____		
	Location: _____		Date of Completion: _____		
Name as it appears on original license: _____					
State	Type		License #	Issue Date	Expiration Date
Original State of Licensure	RN	LP/VN			
Current State of Licensure	RN	LP/VN			
Other State:	RN	LP/VN			
Other State:	RN	LP/VN			
Other State:	RN	LP/VN			
Other State:	RN	LP/VN			
I authorize the _____ Board of Nursing to furnish to the South Dakota Board of Nursing the information requested on page 2 of this form.					
Signature: _____			Date: _____		

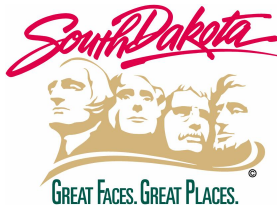
<b>PART II: TO BE COMPLETED BY ORIGINAL STATE OF LICENSURE AND FORWARDED TO THE SOUTH DAKOTA BOARD OF NURSING</b>									
This is to certify that (Applicant Name):									
was issued license #					Type: <input type="checkbox"/> Registered Nurse				
date issued:			expiration date:		<input type="checkbox"/> Practical/Vocational Nursing				
Licensed by:		<input type="checkbox"/> Examination	<input type="checkbox"/> Endorsement	<input type="checkbox"/> Waiver	<input type="checkbox"/> Other:				
Current status:		<input type="checkbox"/> Active	<input type="checkbox"/> Inactive	<input type="checkbox"/> Lapsed	<input type="checkbox"/> Other:				
Has the license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed no probation)?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
Disciplinary Action pending?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", please provide explanation:									
Nursing Education Program Completed:	Institution:				Type of Program				
	Location:		Date Graduated:		DIP		LPN		
					AD		Other:		
					BSN				
Graduation: <input type="checkbox"/> High School <input type="checkbox"/> GED (High School Equivalency) <input type="checkbox"/> 10 <sup>th</sup> Grade									
State Board Test Pool Examination						NCLEX			
Registered Nurse						LP/VN		RN	LP/VN
	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children				
Score									
Series/ Form #									
			Score			Dates Exam Taken			
NCLEX Exam									
State/Provincial Constructed Exam									
Other: (please explain)									
Took CGFNS?									
Yes    No									

**SEAL**

Signature \_\_\_\_\_

Title \_\_\_\_\_

State \_\_\_\_\_ Date \_\_\_\_\_



# SOUTH DAKOTA BOARD OF NURSING

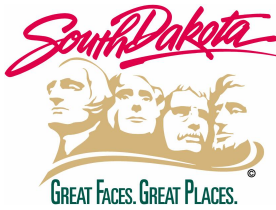
## SOUTH DAKOTA DEPARTMENT OF HEALTH

### VERIFICATION OF EMPLOYMENT

Form 3 page 1 of 1

**To obtain/retain active status license, a nurse must provide verification of employment in nursing of at least 140 hours in any 12-month period or an accumulated 480 hours within the previous six years. If you have not worked practice nursing within the past six years and wish to obtain a nursing license, contact the SD Board of Nursing for more information.**

<b>APPLICANT: Complete the following information and forward this form to your employer or former employer. This form may be duplicated for additional employment verifications. Return the completed form to the South Dakota Board of Nursing.</b>				
Name:				
	First	Middle	Maiden	Last
	Other(s):			
Address				
	Street or PO Box	City	State	ZIP
SS#				
<input type="checkbox"/> I have been employed/volunteered as an <span style="margin-left: 20px;"><input type="checkbox"/> RN</span> <span style="margin-left: 20px;"><input type="checkbox"/> LPN</span> within the last six years.				
<input type="checkbox"/> I have not been employed as a nurse within the past six years.				
I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for licensure purposes.				
Signature of Applicant			Date	
<b>THIS SECTION TO BE COMPLETED BY EMPLOYER</b>				
The above-named individual (was) employed/volunteered as a nurse from _____ to _____ Total hours worked in this period: _____ (date) (date)				
I, the undersigned, declare and affirm that, according to our records, the information provided above for purpose of licensure is true and correct to the best of my knowledge and belief.				
Signature of Agency Representative/Title			Date	
Name of Employer:				
Address of Employer:				
Telephone:			Email:	



**SOUTH DAKOTA BOARD OF NURSING**  
**SOUTH DAKOTA DEPARTMENT OF HEALTH**

Form 4 page 1 of 1

**REQUEST FOR TRANSCRIPT**

<b>APPLICANT: Please fill out the information requested below and forward This form to the Office of the Registrar from your Nursing Education Program.</b>	
<b>Name:</b> _____ First Middle Maiden Last Other(s)	
<b>Address</b> _____ Street or PO Box City State ZIP	
Date of graduation: ____/____/____	SS# _____
Institution: _____	
Location: _____	
I am requesting an official transcript be sent to the South Dakota Board of Nursing for licensing purposes.	
Signature: _____ Date: _____	
<b>REGISTRAR: Please attach this form to the official nursing transcript and send to the South Dakota Board of Nursing at the address below.</b>	



# SOUTH DAKOTA BOARD OF NURSING

## SOUTH DAKOTA DEPARTMENT OF HEALTH

Form 5 page 1 of 1

### APPLICATION FOR ☐ RN ☐ LPN TEMPORARY PERMIT BY ENDORSEMENT

**APPLICANT: COMPLETE ALL QUESTIONS; INCOMPLETE APPLICATIONS WILL BE RETURNED.**

- Temporary Permits are issued for a period of 90 days, and are not renewable.
- South Dakota law prohibits the practice of nursing without a valid South Dakota License or Temporary Permit.
- A Temporary Permit or License is required before you begin orientation at your place of employment.

This application must be accompanied by all three:

1. A photocopy of a current nursing license with expiration date, from any U. S. state or territory
2. Form 1 – Application for Licensure by Endorsement
3. \$125 money order or cashier's check (\$100 fee for endorsement + \$25 fee for temporary permit)

**Name:** \_\_\_\_\_  
                     First                      Middle                      Maiden                      Last                      Other(s)

**Address** \_\_\_\_\_  
   Street or PO Box    City    State    Zip

**School of**    Institution:  
**Nursing**    Location:

#### Indicate which licensure examination you have written:

State Board Test Pool Exam (SBTPE) (Prior to July 1982)	State where exam was written:	Year exam was written:
National Council Licensure Exam (NCLEX)	State where exam was written:	Year exam was written:
Canadian Nurses' Association Testing Services Exam	State where exam was written:	Year exam was written:
Other:	State where exam was written:	Year exam was written:

I will be employed by (Institution): \_\_\_\_\_

Address: \_\_\_\_\_

I will begin employment on (date): \_\_\_\_\_

Note: If employed by a temporary staffing agency, you must provide the name and address of the South Dakota facility in which you will practice nursing.

**RN SUPERVISION REQUIRED:** I understand that, under this Temporary Permit, I am required to practice under supervision of a licensed registered nurse who is on duty in the area where I am practicing.

The RN applicant for licensure by endorsement into South Dakota who has been issued a temporary permit is required to use the initials "RN App." (Registered Nurse Applicant).

The LPN applicant for licensure by endorsement into South Dakota who has been issued a temporary permit is required to use the initials "LPN App." (Licensed Practical Nurse Applicant).

I certify that all information provided on this application for a temporary permit is true to the best of my knowledge and belief.

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date